STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 9752
	)	
Appeal of	)	

INTRODUCTION

The petitioners appeal the decision by the Department of Rehabilitation and Aging (the Department) refusing to renew their license to operate a Level III residential care home. The issue is whether the petitioners were in violation of the statutes and regulations regarding the operation of such facilities.

FINDINGS OF FACT

The petitioners have operated a licensed Level III residential care facility in their home in Middlebury for the past three years. At all times relevant to this proceeding they have been licensed by the Department for no more than five residents. The last license renewal issued by the Department to the petitioners expired on November 30, 1989.

On November 27, 1989, a nurse surveyor for the Department made an unannounced visit (as is routine) to the petitioners' facility in order to conduct an inspection of the licensed premises. She discovered that the petitioners were providing care at that time for six residents--one over their licensed capacity. The surveyor also learned that the RN who provided the "nursing overview" at the petitioners' facility had not

visited the facility since November 2, 1989, and that he was not available for more frequent visits because he was caring for an ill family member. In checking the records that the RN was responsible for maintaining (see infra), the surveyor found several instances of lax and neglected record-keeping. These included: telephone physician medication orders that had not been signed by the physician within fifteen days, an "initial assessment" of a resident who had recently been admitted to the petitioners' facility was missing, "annual assessments" of two other residents were missing, written monitoring of a recently-ill resident had not been done, and the resident register was out of date.

After discussing on that date these and several other "deficiencies" with the petitioners, the surveyor on December 6, 1989, sent the petitioners a written list of the specific deficiencies with a cover letter directing the petitioners within one week to submit a "plan" to bring the home within its licensed capacity, and to submit to the Department a "plan of correction" of the other listed deficiencies by December 20, 1989. The letter also informed the petitioners of their right to request a "variance" from complying with any of the listed deficiencies, and it advised the petitioners of the sanctions that could be imposed if they did not comply. The letter also stated that the petitioners' license was being renewed "for a three month period pending corrections of the various deficiencies

cited".

One of the six residents who was living in the petitioners' home on November 27, 1989, was discharged on December 7, 1989, thus bringing the facility within its licensed capacity. However, the petitioners neither requested a variance nor submitted their "plan of correction" regarding the other listed deficiencies to the Department until January 18, 1990. On the plan the petitioners averred that all the listed deficiencies had been corrected.

On January 25, 1990, the Department's surveyor returned to the petitioners' facility for another inspection. She found that the petitioners' RN had visited the facility only once (on December 2, 1989) since the last inspection two months earlier. Moreover, most of the record-keeping that was supposedly corrected by the petitioners was either incomplete or unavailable for the surveyor's inspection. This included the initial and annual assessments and the medication records noted above, as well as further inadequate records of staff monitoring of ill residents.

From the records that were available, the surveyor noted that two residents had serious medical problems that, in the surveyor's opinion, required vigilant monitoring by an RN. On January 29, 1990, the surveyor called the RN who had been providing the nursing overview at the petitioners' facility. He stated that this was the first time he had been informed of the suicidal ideation by one of the

residents. He told the surveyor that he couldn't attend to his duties at the petitioners' facility as diligently as he would like because of his mother's illness. At the hearing the RN admitted that since the summer of 1989, he was essentially only "on call" and that he had not provided the petitioners' residents with the level of nursing services that he felt was necessary. He also stated that he had told the petitioners in January, 1990, to find someone else because he could not provide the requisite level of RN services. As of the date of the surveyor's visit (January 27, 1990), however, the petitioners had made no effort to secure alternative nursing overview. To date (the last day of hearing was July 5, 1990), the petitioners still hadn't secured another RN to provide nursing overview. The RN had told the petitioners he would remain "on call" until April, 1990. Since April, however, the petitioners' home has had no RN, either present or "on call", whatsoever.

On March 7, 1990, the Department sent the petitioners a notice that it would not renew their license to operate a Level III facility. The petitioners then requested and were granted an in-person review of their case by the Commissioner of the Department. When the Commissioner affirmed the earlier decision (by letter dated March 27, 1990), this appeal followed.

At the hearing, the petitioners contested virtually every deficiency cited by the Department in its November 27, 1989 survey. The hearing officer has confined his

consideration of the evidence, however, to those violations cited by the Department in its March 7, 1990 letter of non-renewal. Of these, the most serious in the view of the hearing officer is the continuing lack of sufficient nursing overview at the petitioners' facility. By the admission of the petitioners' own witness, the RN himself, the petitioners' home has not had adequate nursing overview since March, 1989. The petitioners did little to remedy this situation--in fact, their testimony indicated that they hardly considered it a problem until November, 1989, when the Department's surveyor expressed her concerns.

As to the other deficiencies noted above, the evidence is overwhelming that the petitioners' record-keeping was, and is, lax and haphazard. There is no question that the petitioners did not comply with the Department's directive to submit a "plan of correction" of the cited deficiencies by December 20, 1989. Even when the petitioners did submit their plan (January 18, 1990), a subsequent inspection by the Department revealed that many of the records in question were not available at the petitioners' facility. (see supra). Also, the petitioners continued to be lax in recording the monitoring of certain residents' health problems. In particular, it was discovered that the petitioners had not notified the RN that one resident had expressed suicidal ideations.

Throughout the hearing the hearing officer listened in vain for the slightest indication of contrition by the

petitioners and an acknowledgement by them of the legitimacy of the Department's concerns. Instead, the petitioners' attitude throughout was one of hostility toward the Department and disdain for the regulations and the licensing process. Although the petitioners discharged a resident shortly after the Department's November 27, 1989 inspection, the petitioners gave no indication that this would not happen again if they determined that it was in the best interests of a patient to exceed their licensed capacity.

ORDER

The Department's decision is affirmed.

REASONS

18 V.S.A. ə 2002(1) includes the following definition:

> . . .Residential care homes shall be divided into two groups depending on the level of care they provide, as follows:
>
> a) Level III, which provides personal care, defined as assistance with meals, dressing, movement, bathing, grooming, medication, or other personal needs, or general supervision of physical or mental well being, including nursing overview, but not full-time nursing care.
>
> . . .

Under the law the Agency of Human Services, Department of Rehabilitation and Aging, is the "licensing agency" for Level III care homes. See 18 V.S.A. əə 2002(3) and 2014(a).

18 V.S.A. ə 2008c includes the following (with emphasis added):

> (a) The licensing agency shall enforce provisions of this chapter to protect residents of facilities.
>
> (b) The licensing agency may require a facility to take corrective action to eliminate a violation of a

rule or provision of this chapter within a specified period of time. If the licensing agency does require corrective action:

(1) the licensing agency may, within the limits of resources available to it, provide technical assistance to the facility to enable it to comply with the provisions of this chapter;

(2) the facility shall provide the licensing agency with proof of correction of the violation within the time specified; and

(3) if the facility has not corrected the violation by the time specified, the licensing agency may take such further action as it deems appropriate under this section.

. . .

(d) The licensing agency may, after notice and an opportunity for a hearing, suspend, revoke, modify or refuse to renew a license upon any of the following grounds:

(1) violation by the licensee of any of the provisions of this chapter or the rules adopted pursuant to this chapter;

. . .

(5) failure to comply with a final decision or action of the licensing agency.

The evidence in this case is clear that since March, 1989, the petitioners have not had "nursing overview" at their facility sufficient to ensure the adequate care and monitoring of the residents at the facility. Since April, 1990, the petitioners have had no nursing overview, whatsoever. Thus, regardless of any specific violation of the regulations, the petitioners' facility does not meet the statutory definition of Level III care (see supra). The Department is within its right and discretion to refuse to license the petitioners' facility on this basis alone.

Even it could be concluded that the petitioners maintained a statutorily-adequate level of nursing overview at their facility, there is no question that on December 6, 1989, the Department directed the petitioners to file, by December 20, 1989, a written "plan of correction" of more than twenty "deficiencies" cited as a result of the Department's November 27, 1989 survey of the petitioners' facility. The petitioners did not file this plan until January 18, 1990. At an inspection on January 25, 1990, the petitioners could not and did not produce for the Department's surveyor several of the records that had been cited in the plan. These records included initial and annual assessments and patient medication records.

Section VI(9) of the Department's regulations includes the following provisions:

> a. The licensee shall be responsible for maintaining, filing and submitting all records required by the Licensing Agency. Such records shall be kept current and available for review at any time by authorized representatives of the Licensing Agency.
>
> b. The following records shall be maintained and kept on file
>
> . . .
>
> (2) Resident record . . .
>
> (a) For Level III homes, the record shall contain: initial assessment; annual reassessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition, and/or illness, and action taken; reports of physician visits, signed telephone orders and treatment documentation.
>
> . . .

> c. Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. . .

From the Department's evidence, as well as the petitioners' own admissions, there is no question that the petitioners' records on both November 27, 1989, and January 25, 1990, were not kept in accordance with the above regulation. Even the records that the petitioners introduced at the hearing (some six months later) were fraught with incompleteness, inconsistent entries, and serious errors. At the hearing the petitioners could not even state with credible certainty the present location of many patient records. Thus, not only has the Department established that the petitioners were in "violation" of express provisions of the regulations (see ə 2008c(d)(1), supra), but also that the petitioners failed to "comply" with the specific "action" of the Department on December 6, 1989, regarding the "plan of correction" of the cited deficiencies (see əə 2008c(b) and (d)(5), supra).

Neither the hearing officer nor the Board has the authority to substitute its discretion for that of the Department in licensing matters. Huntington v Dept. of SRS, 139 VT 416 (1981). The evidence (see supra) clearly establishes the facts necessary to conclude that the petitioners were (and continue to be) in violation of the statute and regulations. Moreover, the petitioners' transgressions in this case can hardly be termed de minimus. They have flouted the Department's regulations regarding

resident capacities, nursing care, and record-keeping. Their attitude, even at hearing, was one of contempt and disdain for the regulations and the Department's role in administering them. Clearly, the Department was within its statutory authority and reasonable (arguably, to a fault, is that it has allowed the petitioners' facility to continue operation during the pendency of these proceedings, see 18 V.S.A. э 2008c(e)). in deciding not to renew the petitioners license to operate a Level III residential care home. The Department's decision must, therefore, be affirmed.[1] 3 V.S.A. э 3091(d) and Fair Hearing Rule No. 19.

FOOTNOTES

[1]The record may reflect that the proposed findings of fact and conclusions of law submitted by the Department to the hearing officer were received by the hearing officer within the orally-set time limits imposed after the hearing. The Board deems it inconsequential, however, that the hearing officer did not in his recommendation specifically address these proposed findings and conclusions.

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